Healthpoint

Information from the Division of Health Care Finance and Policy

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Two Boylston Street
Boston, MA 02116
(617) 451-5330

Barbara Erban Weinstein
Commissioner

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MANDATED BENEFITS

Health insurance—or, more precisely, those who lack it—currently is center stage in Massachusetts health policy debates. A related subject, mandated benefits for those who *are* insured, has recently acquired a higher profile, not only in Massachusetts but nationally as well.

All 50 states have laws requiring employers that offer group health plans to include specific benefits. Mandates have come to be for a variety of reasons, from public health concerns to political or financial imperatives. The national law requiring a 48-hour hospital stay for uncomplicated childbirth, for example, reflected angry consumer reaction to health plans' aggressive cost control practices. Some mandates receive little criticism, while others are viewed as government intervention at its worst—"meat-ax regulation," in the words of one commentator. This issue of *Healthpoint* highlights some of the policy issues involving health benefit mandates—when mandates may or may not be appropriate, obstacles to their universal application, and the need for rigorous analysis of their effectiveness, both before and after they are put in place.

What are Mandated Benefits?

States typically mandate that insurers cover specific benefits in all health plans sold, but some states more flexibly mandate that each insurer make a service available in at least one plan that it offers. *Provider mandates* require that the services of a certain provider type (chiropractors, for example) be covered by insurance policies. *Benefit mandates* stipulate that the policy include a minimum level of certain benefits:

30 Massachusetts Mandates

		Number of States*
	Provider Mandates	
1	Chiropractors	41
2	Optometrists	37
3	Podiatrists	38
4	Nurse Anesthetists	12
	Nurse Practitioners	18
5	Dental Coverage	34
6	Certified Nurse Mid-wives	30
7	Any-willing provider- pharmacy freedom of choice	**
8	Provider contracts/compensation re: good faith communication	**
	Benefit Mandates	
9	Mental Health Care	32
10	Alcoholism treatment	43
11	Maternity health Care	13
12	Cardiac Rehabilitation	**
13	Home Care	18
14	Mammography Screening	46
	Cytologic Screening (cervical cancer screening)	16
15	Infertility Benefits (includes IVF)	14
16	Non-prescription enteral formulas for home use	**
17	Lead poisoning screening	3
18	Preventive care for children	26
19	Early intervention services for children	**
20	Diethylstilbestrol exposure	**
21	Off-label uses of prescription drugs to treat cancer	**
22	Low protein food products for inherited PKU	9
23	Bone marrow transplants for breast cancer	8
24	Off-label uses of prescription drugs to treat HIV/AIDS	**
25	Hospice Care	**
26	Blood glucose monitoring strips	**
	Coverage Mandates	
27	Dependent coverage for new born infants...	34
28	Coverage for certain period after insured leaves insurance group	36
29	Divorced or separated spouses; continued coverage	**
30	Refusal to contract with blind or deaf persons: prohibition	**

*number of states either mandating offer and/or coverage
**not available

Sources: United States General Accounting Office
Blue Cross Blue Shield Association

Note: In some cases states limit mandates to particular types of health plans such as HMOs or group insurance plans.

Experimental Treatments

In 1995, Massachusetts mandated that insurance companies cover the infertility treatment method called intracytoplasmic sperm injection (ICSI), soon after the American Society for Reproductive Medicine had declared that it was no longer experimental, but an accepted treatment. There have been no long-term studies of ICSI's safety or effectiveness and biologists say that there may be some definitive risks.

the mental illness mandate in Massachusetts requires that firms offer coverage for up to $500 per year for outpatient services and up to 30 days of residential treatment. *Coverage mandates* provide that insurance plans cover a particular class of individual, divorced or separated spouses who were previously covered, for example.

The average state mandates 18 specific benefits. Sixteen states have over 20 mandated benefits, eight have 10 or fewer and Maryland (39), Minnesota (34), California (33) and Massachusetts (30) have the most mandated benefits.

Mandates Do Not Apply to All Insurance

States use mandates to ensure that their citizens receive specific coverage, yet many citizens, although employed and insured, are beyond the reach of the mandates.

The Employee Retirement Income Security Act of 1974 (ERISA) provides a federal framework for regulating employer-based pension and welfare benefits, including health plans. ERISA preemption blocks states from directly regulating most employer-based health plans, but it permits states to regulate health insurers. The General Accounting Office (GAO) estimates 114 million individuals (44 percent of the US population) are covered by ERISA health plans.

In most ERISA plans, the employer purchases health coverage from a third party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40 percent of these plans, covering about 44 million people, the employer chooses to self-fund and retain the risk for its employees' health care costs. Since these self-funded plans are not "insurance," ERISA exempts them from state regulation and premium taxation. If we extrapolate this national figure to the Massachusetts population, an estimated 1.2 million people in the state are in insurance plans that are self-funded and therefore exempt from mandates.

Why mandate?

A philosophical aspect of the debate over mandates involves the imposition of regulation into what is otherwise a relatively free market, with many buyers and sellers. Proponents of mandates focus on equity and access issues. Mandates may protect some insurers from adverse selection—that is, attracting sicker members who are more likely to incur high costs. They may reduce the utilization of more expensive resources by mandating coverage for less-costly alternative services. From a public health standpoint, mandates such as immunization provide access to fundamental services of value to society that some would be unable or unwilling to acquire on their own. Finally, mandates may bring credibility to certain providers.

Why not mandate?

Those opposed to mandates contend that mandates distort costs and interfere with the functioning of the market. Mandates may cause premium costs to rise and encourage some employers to self-fund or discontinue coverage to avoid mandates. There is a risk of over-utilization of medical services, which would lead to rising prices for health services. Mandates might also infringe on

employee-management relations by imposing a benefit package different from what is called for: a "Cadillac" plan where a "Chevrolet" is appropriate.

What is the impact of mandates on costs of insurance?

The cost impact of mandated benefits depends on the nature and scope of each state's regulations and on health plans' typical operating practices. Available studies reflect this cost variation, estimating higher claims cost in states with the most, and most costly, benefits. As an example, Blue Cross Blue Shield of Massachusetts estimates that mandated benefits add 20 percent to their major medical plan rates. In addition, multi-state employers claim that variation in mandates across states adds to administrative costs.

Though mandates may increase costs, estimates of their incremental cost may exaggerate the differences between insured and self-funded health plans. Many commonly mandated benefits are often covered by employers who self-fund, even though they are not subject to state regulation. Studies conducted in the 1980s found that self-funding in order to avoid mandates was a popular strategy for controlling premium costs. This trend is changing, with firms providing more consistent benefits and turning now to managed care to contain costs. Therefore, mandates may cost employers who are technically exempt from them almost as much as those who are not.

Definitive information on the costs and cost effectiveness of existing and proposed mandates is sparse, especially given the potential impact of mandates on the cost of health care. Policy deliberations would seem to demand such cost information, yet studies are limited and inconclusive.

Policy Implications

The universal appeal of some mandates creates the popular impression of a consensus that insurance policies should provide these benefits and that, unless the state requires them, insurers are not likely to include them. This may or may not be the case. If permitted, would insurers eliminate newborn coverage? Probably not. Would they eliminate or reduce coverage of mental health? Possibly. Plans exempt from state mandates cover as many or more benefits as non-exempt plans, suggesting that factors beyond mandates influence coverage decisions. Important policy issues to consider include the costs, effectiveness and appropriateness of mandates, and their effect on access to health care.

Premium costs. The efficacy of state mandates has become an important issue in the debate over reform of the US health care system. Many mandates have been promoted by lobbyists and interest groups for specific health-service groups or patients with certain diseases. The potential cost of these mandates was not a primary consideration. Legislating a two-day maternity stay raises health insurance costs by just a fraction of a percent. In sum, however, mandates contribute what may be significant additional costs that increase premiums.

Cost-Effectiveness Debated

In 1993, arguing against the state insurance mandate of covering IVF treatments, the Massachusetts Association of HMOs calculated that each live birth conceived through IVF cost about $100,000, more than 10 times as much as a complication-free vaginal birth. In 1994, a study of deliveries at Brigham and Women's Hospital found that multiple gestation pregnancies resulting from reproductive technology added more than $3 million a year to the hospital's costs as a result of complications, neonatal intensive care and other expenses. However, according to Resolve, a national infertility advocacy and education organization, the cost to payers of mandated infertility treatment coverage is only 0.4 percent of the monthly premium.

Unintended consequences? An important question in evaluating state-mandated benefits is the extent to which mandating that all insurers include particular health insurance benefits will lead some employers to drop their insurance coverage altogether. Mandates for which the perceived benefits may be the largest (mental illness) are also potentially the most expensive, although it can be argued that preventive services might offset the need for more expensive treatment in the long run. Losing all insurance coverage could have much larger consequence for an individual and for society than gaining coverage for a specific benefit.

Comprehensiveness. States view ERISA as an impediment to ensuring adequate consumer protections for all individuals with employer-based health coverage and to enacting reforms that would improve the efficacy, equity and efficiency of the health care market. States maintain that they should be able to treat all participants uniformly. ERISA makes benefit mandates a less effective tool for accomplishing this goal.

The Need for Analysis. No single analytical tool will be a substitute for the political and social processes required to implement health policy. Cost-effectiveness and cost benefit analyses, however, can organize information in a manner that will allow more reasoned assessments of the options available. A step in this direction is that Massachusetts law now requires rigorous evaluation of the autologous bone marrow transplant and the two-day maternity length of stay benefits.

Conclusion

Mandates heavily influence the health care that a population receives, though an underlying state strategy for health care delivery is often not evident. Policy makers should consider all of the above policy implications, in a systematic way, when considering a new mandate. With health care dollars scarce, they may want to analyze the tradeoffs in cost, access and effectiveness that are implicit in mandating benefits, as well as evaluate those mandates already in place.

Further Reading

US Government Publications:
General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*. August 1996, GAO/HEHS-96-161
General Accounting Office, *Employer-Based Health Plans: Issue, Trends and Challenges Posed by ERISA*. July 1995, GAO/HEHS-95-167

Other Sources:
Dolores Kong, "What Price Pregnancy?", *Boston Globe*, August 5, 1996
"Alternative Medicine not so Unconventional: Commentary", *Modern Healthcare*, May 6, 1996
Gregory Acs et al., "Data Watch: Self Insured Employer Health Plans", *Health Affairs*, Summer 1996

Did you know?

Use of the Uncompensated Care Pool

Age Group by Payer

Age Group	Percent of Discharges to Total UC Pool	Medicaid	All Payers
0 — 17	12%	37%	17%
18 — 34	35%	32%	18%
35 — 64	41%	28%	28%
65 & above	12%	3%	37%

Inpatient Major Diagnostic Category by Payer

Top Five Free Care Major Diagnosis Categories	Percent of Discharges to Total UC Pool	Medicaid	All Payers
Circulatory System	11.7%	5.6%	17.1%
Respiratory System	9.6%	8.3%	9.9%
Pregnancy, Child Birth	9.3%	21.0%	11.6%
Mental Disease & Disorders	8.6%	6.2%	4.4%
Digestive System	8.4%	4.8%	8.2%

Source: DHCFP hospital discharge and uncompensated care pool claims data

Staff for this publication:

Harry Lohr
Robert Seifert
Heather Shannon
Brian Shea
Pramila Vivek